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RESEARCH PAPER



Exploring participatory behaviour of disability benefit claimants from an insurance physician's perspective

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ABSTRACT

Purpose: In the Dutch social security system, insurance physicians (IPs) assess participatory behaviour as part of the overall disability claim assessment. This study aims to explore the views and opinions of IPs regarding participatory behaviour as well as factors related to inadequate participatory behaviour, and to incorporate these factors in the International Classification of Functioning, Disability and Health (ICF) biopsychosocial framework.

Method: This qualitative study collected data by means of open-ended questions in 10 meetings of local peer review groups (PRGs) which included a total of 78 IPs of the Dutch Social Security Institute. In addition, a concluding discussion meeting with 8 IPs was organized.

Results: After qualitative data analyses, four major themes emerged: (1) participation as an outcome, (2) efforts of disability benefit claimants in the process of participatory behaviour, (3) beliefs of disability benefit claimants concerning participation, and (4) recovery behaviour. Identified factors of inadequate participatory behaviour covered all ICF domains, including activities, environmental, and personal factors, next to factors related to health condition and body functions or structures. Outcomes of the discussion meeting indicated the impossibility of formulating general applicable criteria for quantifying and qualifying participatory behaviour.

Conclusions: Views of IPs on disability benefit claimants' (in)adequate participatory behaviour reflect a broad biopsychosocial perspective. IPs adopt a nuanced tailor-made approach during assessment of individual disability benefit claimants' participatory behaviour and related expected activities aimed at recovery of health and RTW.

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KEYWORDS

Participatory behaviour; disability assessment; return-to-work; qualitative research; health recovery

► IMPLICATIONS FOR REHABILITATION


- Within a biopsychosocial perspective, it is not possible to formulate general criteria for the assessment of participatory behaviour for each unique case. Individual disability benefit claimant characteristics and circumstances are taken into account.
- To optimize the return-to-work (RTW) process, insurance physicians (IPs) assess participatory behaviour according to the International Classification of Functioning, Disability and Health, including medical, personal, and environmental factors.
- Some aspects within the concept of participatory behaviour extend beyond the boundaries of the domain where IPs operate because opinions in society on personal and societal responsibility influence participatory behaviour.

Introduction

Unemployment due to long-term disability is associated with both personal costs, that is, loss of income, reduced quality of life, and higher morbidity and mortality rates, and with substantial societal costs [1]. Therefore, in the last decades, many European countries have reformed their disability benefit policies to prevent long-term sickness absence, to reduce the inflow into disability, and to promote return-to-work (RTW) of disability benefit claimants [2]. As part of many of these reforms, focus has shifted away from

assessing disability on predominantly medical grounds to the assessment of remaining work capacity of disability benefit claimants.

The focus on "ability" instead of "disability" is in line with the biopsychosocial framework of the WHO, the International Classification of Functioning, Disability and Health (ICF) [3]. The ICF is a biopsychosocial classification system that describes disability as an umbrella term referring to the negative aspects of the interaction between a person's health condition and the environmental and personal factors. In social security systems of many

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countries, the ICF is becoming more and more accepted as a framework to describe human functioning in disability assessment [4]. The use of the ICF may support the assessment of factors that influence disability by providing a common point of reference for the ability of a person to work.

In many countries, disability benefit claimants with residual work capacity are obliged to participate actively in job search activities. In some European countries, for example, Austria, Germany, Switzerland, and the Netherlands, participation requirements of disability benefit claimants are laid down by law [2,5]. In the Dutch social security system, insurance physicians (IPs) who assess the functional limitations of disability benefit claimants are also required to assess whether disability benefit claimant's activities and behaviour during the period of sick leave have been adequately directed at recovery of health and RTW. In Box 1, general information on the social security legislation in the Netherlands and the tasks of Dutch IPs is provided.

Box 1 GENERAL INFORMATION ON THE SOCIAL SECURITY LEGISLATION IN THE NETHERLANDS AND THE TASKS OF DUTCH INSURANCE PHYSICIANS (IPs)
To cover employee disability in the Dutch social security system, insurance is provided under the Work and Income According to Labour Capacity Act (WIA). This disability insurance is implemented by the Dutch Social Security Institute (SSI), which is an autonomous administrative authority commissioned by the Ministry of Social Affairs and Employment. Besides providing timely financial compensation for those unable to work, the mission of SSI is to support sick-listed workers to return to their own or other suitable work. Employees who have been sick-listed for their own work for a period more than one and a half year can apply for disability pension under the WIA. In this period, employer and employee are required to do their utmost for the work rehabilitation of the sick-listed employee. IPs and labour experts (LEs) from the SSI have to assess these rehabilitation efforts, including the participatory behaviour of the sick-listed employee. If these efforts have been inadequate, the SSI may impose a sanction to the employer and/or employee. Disability benefit is assessed only if everything possible has been done to rehabilitate the sick-listed employee. General work ability is then assessed by IPs in face-to-face interviews and physical examinations. If needed, and only with informed consent of the claimant, additional information is requested from treating physicians. IPs assessing the disability benefit claim focus on the medical condition (disease, symptoms, impairments), functional status (limitations of activities), and prognosis. Next, LEs determine the loss of earning capacity resulting from functional impairments caused by illness and support the claimant to return to suitable work.

To support IPs in this assessment, in 2009, a practice-based guideline was developed by a multidisciplinary group of insurance and occupational physicians, general practitioners, psychologists, legal experts, and representatives of patient organizations. This guideline was subsequently peer-reviewed, authorized and published in 2010 by the Dutch Association of Insurance Medicine (NVVG) [6]. This guideline contains the concept "Participatory behaviour" and defines it as "the behaviour of disability benefit claimants aimed at health improvement for the purpose of RTW." Although written by and for IPs, who focus on medical aspects of participatory behaviour, the guideline emphasizes that the assessment of participatory behaviour is not limited to medical factors alone. It includes both medical and psychosocial factors influencing job search behaviour. Conform this guideline, IPs assess participatory behaviour. Moreover, they identify health-related, environmental, and personal factors that influence this behaviour, using the ICF [3] for guidance. Within the ICF framework, participatory behaviour of disability benefit claimants can be placed in the domain activities.

Literature on the RTW process shows the significant impact of many health-related, personal, and environmental factors [7–11]. To our knowledge, however, only two studies, both performed in

the Netherlands, specifically focused on factors of participatory behaviour from the perspective of IPs who assess this behaviour. A small-scale survey among 49 IPs conducted in 1998 indicated the relevancy of health- and healthcare-related factors while assessing participatory behaviour [12]. Another survey among 469 medical professionals, including both occupational physicians and IPs [6], was conducted in 2010 within the context of the aforementioned NVVG guideline. IPs considered the assessment of participatory behaviour to be part of the overall disability claim assessment. They regarded participatory behaviour from a broader biopsychosocial viewpoint, including recognizing and describing delayed RTW. They motivated disability benefit claimants who they considered as showing inadequate participatory behaviour, to initiate RTW activities. Furthermore, they offered disability benefit claimants and other stakeholders in the RTW process, that is, labour experts and re-integration supervisors, potentially more effective re-integration activities. For example, part-time instead of full-time return to one's own work and exploring possibilities to return to other suitable work.

To further explore IPs assessment of participatory behaviour, research is needed to provide more knowledge on factors that influence participatory behaviour. For this reason, as a first step in the empirical cycle, using the definition of participatory behaviour in the NVVG guideline as a starting point, the present qualitative study aims to explore "participatory behaviour" from the perspective of IPs who assess participatory behaviour as part of the disability benefit claim. The second aim is to identify factors that, according to IPs, are related to (in)adequate participatory behaviour and to incorporate these factors in the ICF biopsychosocial framework.

To the best of our knowledge, this is the first study that explores participatory behaviour in a disability assessment setting, using the biopsychosocial approach of the ICF as a guiding framework as theoretical perspective.

Methods

Design

The present study is a qualitative exploratory study in which both explicit and implicit knowledge of IPs working at the Dutch Social Security Institute (SSI) and participating in a peer review group (PRG) are used as a source of information. In Box 2, general information on the use of PRGs is provided.

Box 2 GENERAL INFORMATION ON PEER REVIEW GROUP MEETINGS (PRGS)
PRGs make use of intervision, which is the multilateral exchange between equals and offers the opportunity to efficiently use the expertise available in a team or group of professionals [13]. This form of work-related learning is aimed at increasing knowledge, improving skills, increasing self-reflection, and insight in personal functioning. Furthermore, it offers a platform for exchanging opinions, facilitates agreement and shared understanding, and enhances consensus. During PRG meetings, which are guided by a non-hierarchical chairperson, IPs discuss a variety of topics, chosen in agreement with the members. These topics are related to issues from daily clinical practice (e.g., client case histories, aspects related to assessment of work disability), as well as topics related to more general professional issues regarding insurance medicine. In general, PRG meetings have a duration of 2 hours with a group size of 8–10 IPs.

The results from the PRGs were used as input for a concluding discussion meeting with IPs recruited from the PRGs. This meeting aimed to integrate knowledge obtained from the PRGs, to discuss topics that needed clarification, and to explore the applicability of the results to daily clinical practice.

Participants

The sample consisted of IPs who participated in PRGs organized in the north-eastern part of the Netherlands. The chairman of each PRG received information about the study by telephone and email, and was requested to pass the information to the members of their PRG. The chairman of each group investigated the willingness of the members to accept the invitation for participating in this study. After receiving consent of the chairman, information about the aim and the topic of the study, as well as the data collection forms (response lists with open-ended questions) were distributed to all study participants of the invited PRGs. The chairman received a written instruction and guideline how to lead the meeting. The researcher (CJS) gave additional explanation by telephone as well. By consent of the chairman, all IPs of the respective PRG were included as study participants. According to Dutch law, ethical clearance was not required for this qualitative exploratory study.

Participants of the discussion meeting were recruited from the PRGs. Chairmen of the PRGs were asked if a member of their PRG was interested to participate in the discussion meeting. In addition, a member of the working committee of the NVVG guideline for IPs on participatory behaviour [6] participated in the discussion meeting.

Data collection

Data were collected during a regular scheduled meeting of the PRGs between November 2012 and April 2013. At the start of the meeting, study participants were given approximately 15 minutes to answer three open-ended questions on response forms on the following three topics: (1) description of adequate participatory behaviour (question 1: "What do you mean by the term adequate participatory behaviour?"); (2) inadequacy of participatory behaviour (question 2: "When, in your opinion, is participatory behaviour inadequate?"); (3) factors associated with inadequate participatory behaviour (question 3: "Which factors in your opinion are associated with long-term inadequate participatory behaviour of disability benefit claimants?"). Study participants were invited to answer the questions of the response forms by writing out their thoughts on the subject. In addition to these questions, data on socio-demographic and professional characteristics of the IPs were collected.

Next, the chairman guided the plenary discussion about the three topics to sample additional information as a result from the group discussion, and wrote down the outcomes on a flip-chart. Much information from the plenary discussion written on the flip-charts was already mentioned in the question response forms. If not, the additional information was added to the data that were analysed. Data collected by the response forms and flip-charts were synthesized and both used for analysis. Question response forms and the flip-charts were returned to the research team. All response forms were sent to CJS. To test this data collection procedure, a pilot study in one PRG was performed and minor adjustments were made.

For the follow-up discussion meeting, which was organized in September 2013 (duration 2 h), the authors reviewed the results of the PRGs and identified those topics that were considered as being abstract or unclear, and consequently needed further exploration and clarification. After an introduction on the aim of the meeting, participants were invited to reflect on and give their opinion about the topics presented. The moderator (CJS) facilitated the discussion and two co-authors (SFM, SB) took notes. To support these notes, the discussion meeting was audio-recorded.

Data analysis and synthesis

Responses of IPs on questions 1 and 2 of the open-ended question response forms and the information on the flip-charts were analysed according to guidelines for qualitative data analysis [14]. Two researchers (CJS and SFM) independently assigned codes to each of the responses of the first two PRGs. A code could range from a single word to a set of words that captured the essence of the connected text on the response form. Independently assigned codes were compared and discussed until consensus on the most appropriate code was reached. In case of disagreement, other authors (SB and JvdK) were consulted. CJS coded the remaining response forms and the accuracy of all codes was checked by SFM.

After three PRGs had been coded, a pattern of repeatedly used codes emerged. When all PRGs were coded, these codes were imported into a Word spreadsheet and compared in terms of similarities and differences. Codes were clustered into categories and subsequently organized into subthemes, and finally on a more abstract level into themes. This procedure and the outcomes were discussed with the other researchers (SB and JvdK) until consensus was reached on the final themes and subthemes.

For analysis of data on question 3 of the open-ended question response forms, the listed factors of inadequate participatory behaviour were grouped according to the ICF by two researchers (CJS and SFM) independently. Results were compared and discussed with SB and JvdK. For this purpose, the expanded ICF scheme that includes work-related factors, as developed by Heerkens et al. [15] and elaborated by Minis et al. [16], was adopted.

Information gathered during the discussion meeting was summarized by SFM and SB independently. These summaries were synthesized by CJS and submitted to the research group (CJS, SFM, and SB). Based on these summaries, conclusions from the discussion meeting were formulated in a final discussion between all authors.

Results

In all, 11 PRGs were invited and all consented to participate in this study. One PRG was excluded since participatory behaviour was not discussed in this group due to the chairmen's absence and cancellation of the next meeting because of the low attendance rate of IPs. Six of the PRGs were located in the northern region of the Netherlands and four in the eastern region. A total of 78 IPs was included. Group size per PRG ranged from 5 to 11 IPs.

The discussion meeting was attended by eight IPs from six different PRGs, including two staff IPs and one IP of the working committee of the NVVG guideline on participatory behaviour. Descriptive characteristics of both study groups are presented in Table 1.

Description of participatory behaviour and the (in)adequacy of this behaviour

Analyses of data on the response forms including data from the plenary discussions during the PRGs regarding question 1 (description of adequate participatory behaviour), resulted in 83 different codes based on 442 text fragments. Data on question 2 (inadequacy of participatory behaviour) resulted in 41 codes based on 444 text fragments. We identified four major themes with a total of 11 subthemes (Table 2). The major themes are as follows: (1) "participation as an outcome"; (2) "efforts of disability benefit

Table 1. Descriptive characteristics of IPs participating in the peer review groups (PRGs; $n = 78$) and the discussion meeting (DM; $n = 8$).

Characteristics	PRGs	DM
Age, years ^a	51.4 (6.4)	54.8 (4.1)
Male ^b	40 (56)	5 (63)
Specific expertise ^c		
Work and Income according to Labour Capacity Act	23 (33)	1 (13)
Sickness Benefits Act	28 (40)	0
Invalidity Insurance Act for Young Disabled Persons	6 (9)	1 (13)
Objection and Appeal	4 (6)	1 (13)
All round/combination/other	9 (13)	2 (25)
Staff insurance physician	0	2 (25)
NVVG member	0	1 (13)
Work experience, years	15.9 (8.6)	20.5 (5.6)
Location of PRG		
SSI region North:		
Assen/Emmen (1 office)	9 (12)	2 (25)
Groningen (3 offices)	22 (28)	2 (25)
Leeuwarden (2 offices)	14 (18)	1 (13)
SSI region East:		
Apeldoorn (2 offices)	14 (18)	2 (25)
Zwolle (2 offices)	19 (24)	1 (13)

Data are presented as mean (SD) or numbers (percentage).

^a9 missing values for PRGs.

^b7 missing values for gender.

^c8 missing values for PRGs.

NVVG: Dutch Association of Insurance Medicine; SSI: Social Security Institute.

Table 2. Themes and subthemes identified.

Theme	Subtheme
1. Participation as an outcome	<ul style="list-style-type: none"> • Participation in work • Participation in other life domains
2. Efforts of disability benefit claimants in the process of participatory behaviour	<ul style="list-style-type: none"> • Work-related activities • Activities related to participation in other life domains • Content and quality of activities • Quantity of activities
3. Beliefs and attitudes of disability benefit claimants concerning participation	<ul style="list-style-type: none"> • Motivation • Receptivity towards RTW
4. Recovery behaviour	<ul style="list-style-type: none"> • Improvement of functioning • Improvement of health • Improvement of lifestyle

claimants in the process of participatory behaviour"; (3) "beliefs and attitudes of disability benefit claimants concerning participation"; and (4) "recovery behaviour." Responses of IPs on inadequate participatory behaviour seemed often to be exactly the opposite of their responses on adequate behaviour. Therefore, the results of both questions are merged and discussed together into each theme.

Participation as an outcome

The first theme relates to (in)adequate participatory behaviour as an outcome, both in work and in other life domains besides work.

Participation in work

IPs associated participatory behaviour with participation in work, by most specified in more detail as full-time or part-time RTW. Work should be in accordance with individuals' abilities and with use of remaining work capacities. Moreover, participation in work should not lead to frequent sickness absence. For some IPs, participation in work should consist of RTW in the former job at the former employer. For others, it also includes performance in work other than the former job, at another employer or self-employment. Regarding work content, IPs indicated that working with

work accommodations was also regarded as participatory behaviour.

Many IPs stated inadequate participatory behaviour simply as the "client doesn't work" or "client refuses to work." IPs differed in further specifications: for some, it relates to an insufficient number of hours worked (e.g., "working part-time"), for others, it relates to not fully employing remaining work capacities (e.g., "unwillingness to do adjusted work despite sufficient work capacity").

Participation in other life domains

Besides participation in work, IPs identified domains of participation in other life areas such as voluntary work, housekeeping, meaningful daytime activities, social activities, private life, and participation in one's own social context. More broadly, "participation in society" was reported as an example of participatory behaviour.

For some IPs, insufficient participation in other life areas is seen as inadequate participatory behaviour (e.g., "insufficient participation in voluntary work" and "insufficient participation in private life or at home").

Efforts of disability benefit claimants in the process of participatory behaviour

The second theme related to efforts of disability benefit claimants. It aimed at the content and the quality and quantity of the activities undertaken by disability benefit claimants to reach participation in work or in other life domains.

Work-related activities

IPs reported a broad range of activities that disability benefit claimants may undertake to realize participation in work. Activities could be part of efforts to realize participation in work in general, or more specifically efforts aimed at RTW in the former job, another job, or participation in adapted work or work with accommodations. In addition, activities could be aimed at finding a new job by means of applying for a job or following a trajectory towards work, re-integration, and cooperation in re-integration. Also several educational activities were seen as part of the process of participatory behaviour such as general education, retraining, supplementary training, and training in job application. Some IPs added that education should be performed without frequent sickness absence.

Insufficient efforts were expressed as the opposite situation from the former paragraph (e.g., "client is not cooperating in a re-integration trajectory"; "client does not or insufficiently apply for jobs"; "client is not following retraining or supplementary training").

Activities related to participation in other life domains

Some of the IPs listed efforts to realize participation in other life domains besides work, that is, voluntary work, and efforts to realize participation in society in general as belonging to the process of participatory behaviour. IPs reported on insufficient participation in other life domains (e.g., "no or insufficient participation in voluntary or unpaid work" and "client functioning at home or in the direct environment is insufficient").

Content and quality of activities

IPs reported many adequate activities of disability benefit claimants to realize participation in work and other life domains. Key element is that IPs expect disability benefit claimants to adopt a

pro-active approach to realize participation (e.g., “client undertakes action,” “active engagement of client,” “client makes an effort”). Other listings by IPs could be categorized as taking initiative (e.g., “asking for help,” “searching for solutions,” “taking timely action,” “taking action in case of recovery,” “seeing and creating opportunities,” “taking responsibility”), and being communicative (e.g., “cooperative behaviour,” “feedback behaviour,” “following given advice,” “keeping appointments,” “keeping relevant contacts”). In addition, IPs identified several activities related to inadequate activity behaviour. Concerning the content of activities, they listed, for example, “inappropriate activities,” “prioritizing of other activities,” “no use or insufficient use of work opportunities or abilities,” and “client has no structure or regularity.” Related to insufficient initiative, IPs also reported “client does not ask for help,” and insufficient cooperation was reported as “client is not cooperating,” “client is resistant,” “client does not adhere to advice or instructions,” “client is not keeping appointments,” and “client discontinues activities.”

Quantity of activities

IPs varied in their opinions on the degree of efforts and activities they expected from disability benefit claimants. This ranged from the maximum possible activity level, expressed as “doing everything” and “undertake all that is possible,” to an optimal level and to activity behaviour described as “adequate” and “sufficient.” Some IPs had the opinion that the degree of activities should be in accordance with disability benefit claimants’ abilities. Insufficient activity was expressed as the opposite again, in a range from “not doing the maximum possible” to “not doing the optimal” to “insufficient activities,” expressed as “passivity,” “inactivity,” and “waiting.” Some IPs reported “client is not doing what is in accordance with the abilities” as insufficient activity.

Beliefs of disability benefit claimants concerning participation in work

The third theme related to beliefs and attitudes of disability benefit claimants in terms of motivation and receptivity towards RTW.

Motivation

Only a few IPs reported aspects that relate to disability benefit claimants’ motivation to participate in work or to undertake activities to realize participation in work. Besides motivation to participate in work per se, IPs deemed motivation to receive support and guidance a relevant aspect, as well as a “positive attitude towards activities.” In addition, disability benefit claimants’ individual needs and goals play a role expressed as “need for participation in the labour force” and “participation as the clients’ goal.” Some IPs identified a lack of motivation and “other needs or other priorities of clients” as relevant aspects. One IP listed externalizing of disability benefit claimants regarding barriers of RTW as indicative of lack of motivation.

Receptivity towards RTW

A few IPs identified being receptive for participation in the labour force and being receptive for behavioural change as relevant aspects of participatory behaviour of claimants. Some IPs reported about obstructing cognitions of disability benefit claimants such as “client thinks he can’t work and he thinks he can’t do anything about it,” “client’s fixation on impossibilities with deconditioning

as a consequence,” “client fixes on problems rather than on possibilities,” and “catastrophizing thoughts.”

Recovery behaviour

The fourth theme related to participatory behaviour is “recovery behaviour.” This term was frequently used by IPs to describe behaviour aimed at improvement of functioning, health, and lifestyle.

Improvement of functioning

IPs identified improvement of functioning, capacities, and limiting existent impairments as relevant, expressed as “activities that aims to reduce the impairments that clients experience,” or more general “increasing the possibilities” and “behaviour aimed at possibilities instead of impairments.” Inadequate recovery behaviour was expressed as “client does not everything possible to improve functioning.”

Improvement of health

IPs expect disability benefit claimants to be active and cooperative regarding improvement of health by medical treatment (e.g., “following treatment advice”), which should be evidence-based and performed according to protocols and guidelines. Inadequate recovery behaviour was expressed as “client does not show enough recovery behaviour” and “client is not participating in his own recovery.”

Improvement of lifestyle

IPs expect disability benefit claimants to perform healthy behaviour regarding alcohol consumption, physical activity, smoking, weight control, and dietary habits. Inadequate recovery behaviour as expressed in unhealthy lifestyle was expressed as “client keeps an unhealthy diet,” “client is using alcohol,” “client is using drugs,” “client is lacking physical exercise,” and “client continues smoking despite cardiovascular disease.”

Factors of inadequate participatory behaviour

Factors of inadequate participatory behaviour as listed by IPs were grouped according to the ICF (Figure 1).

Relevant factors considering impairment in “Body functions or structures” were pain, mental functions (e.g., personality, anxiety, depression, autism, mental retardation), and cognitive functions (e.g., lack of insight, limited capacities). Furthermore, IPs listed a range of negative emotions as hampering participatory behaviour such as anger, frustration, and discouragement. As part of the “Health condition,” IPs reported co-morbidity and severity of disease as risk factors of inadequate participatory behaviour. Within the “Activities” domain, work capacity was seen as an influencing factor.

With respect to “Environmental factors,” the many factors that were listed were aggregated to four main categories: (1) support and relationships, (2) attitudes, (3) health, occupational and social security services, and (4) work-related factors. “Personal factors” related to three main categories: (1) general factors, (2) health condition related factors, and (3) work-related factors.

Integration of results from PRGs

Based on the results on the PRGs, after iterative discussion between all researchers (CJS, SFM, SB, and JvdK), seven topics were identified as being abstract or unclear, and therefore

needed further clarification in the discussion meeting. Identified topics were as follows: (1) active behaviour of disability benefit claimants; (2) required degree of disability benefit claimants' efforts to realize participation; (3) adequacy of disability benefit claimants' attitude; (4) benefits of being sick listed; (5) criteria for medical treatment; (6) relevancy of lifestyle; (7) desired outcome of adequate participatory behaviour, including sustainability of RTW. The results from the discussion meeting are presented in Box 3.

Box 3 TOPICS AND RESULTS OF THE DISCUSSION MEETING

1. *Behaviour of disability claimants: meaning of "being active"*
It is not possible to formulate general applicable criteria for quantifying and qualifying activities of claimants because re-integration activities depend on stage and severity of disease and treatment.
2. *Required degree of disability benefit claimants' efforts: distinction between adequate and inadequate participatory behaviour*
It is not possible to formulate a general cut-off point for inadequate participatory behaviour because claimants' abilities and context influence the potential range of re-integration activities. Maximal efforts of an individual claimant can be assessed as insufficient in another claimant.
3. *Attitude of claimants*
Resistance of claimants is nominated as inadequate participatory behaviour. Passivity may be a consequence of lack of claimants' competencies or ineffective coping. If these claimants follow and adhere to given advice and instructions, their participatory behaviour cannot be judged as inadequate.
4. *Benefits of being sick listed: secondary gain of disability benefits*
"Secondary gain" is an ill-chosen expression because there is little gain in being ill and being disabled. However, behaviour of claimants related to secondary gain should be regarded as inadequate participatory behaviour.
5. *Criteria for medical treatment*
It is not possible to formulate criteria regarding adequacy of medical treatment because of differences between types and burden of treatment, expected treatment results, and the specific situation of the claimant.
6. *Relevancy of lifestyle*
Lifestyle is not a medical disorder and is as such not a component of the assessment of participatory behaviour as performed by insurance physicians.
7. *Desired outcome of adequate participatory behaviour*
General applicable criteria regarding outcomes of participatory behaviour cannot be formulated because context, characteristics and circumstances of claimants, as well as conditions of social security insurance influence expectations regarding outcomes. With respect to sustainability of RTW, unpredictable external factors may interfere with continuation of RTW. For this reason, IPs cannot predict long-term outcomes.

According to IPs, it is not possible to formulate criteria for quantifying and qualifying participatory behaviour (number and nature of expected activities) aimed at recovery of health and RTW that are applicable to all disability benefit claimants. Instead,

IPs emphasized that for each individual disability benefit claimant individual circumstances, such as stage and severity of disease, treatment, personal, environmental, and cultural factors should be weighed.

Discussion

In this qualitative study, we explored views and opinions of IPs on participatory behaviour and made an inventory of factors related to adequate and inadequate participatory behaviour. For this purpose, data were collected among 78 IPs participating in 10 local PRGs. In addition, a concluding discussion meeting was organized in which eight IPs took part.

Our study is a first empiric step towards better understanding of the complex and under-researched construct participatory behaviour, starting from the perspective of IPs. In our view, participatory behaviour is best explored by eliciting explicit and implicit knowledge of IPs constructed through interaction with colleagues.

Results regarding participatory behaviour were synthesized into four major themes: (1) participation as an outcome addressed participation in work and in other life domains besides work, such as voluntary work, housekeeping, and social activities. Work-related issues were weekly working hours, work characteristics, and the match between an individuals' work capacity and job tasks; (2) efforts of disability benefit claimants in the process of participatory behaviour regarding work and participation in other life domains. These efforts were described in terms of content and quality (attitude, communication, showing initiative) and quantity of activities (ranging from sufficient to maximum possible); (3) beliefs of disability benefit claimants concerning participation such as motivation and receptivity towards RTW, and (4) recovery behaviour aimed at improvement of functioning, health, and lifestyle.

In-depth reflection during the discussion meeting confirmed viewpoints of IPs in the PRGs that not only factors related to health condition and body functions must be taken into account, but also environmental and personal factors. In the discussion meeting, it was concluded that IPs in their assessment of adequate participatory behaviour adopt a nuanced tailor-made approach within the biopsychosocial framework of the ICF. Criteria for (in)adequate participatory behaviour vary in each individual case, depending on individual assessment of ICF factors, and are not generally applicable to all disability benefit claimants.

Our study shows that IPs, with regard to "adequate participatory behaviour," adhere to the NVVG guideline by not exclusively focusing on medical treatment and recovery of health, but also on participation in work and other life domains. This is illustrated by the fact that IPs expect disability benefit claimants to be active and cooperative regarding medical treatment. This is in line with their traditional view that medical- and health-related aspects are most important in recovery behaviour [12], reflecting the medical background and perspective of IPs. In addition, IPs also associate participatory behaviour with work, work-related activities, and efforts to realize participation in work. If participation in work cannot be achieved, they expect disability benefit claimants to participate in life domains other than work. It seems that since the aforementioned NVVG surveys in 1998 and 2010 [6,12] were conducted, the focus of IPs in their assessment of participatory behaviour in disability benefit claimants has further shifted from an exclusive medical point of view to a broader biopsychosocial

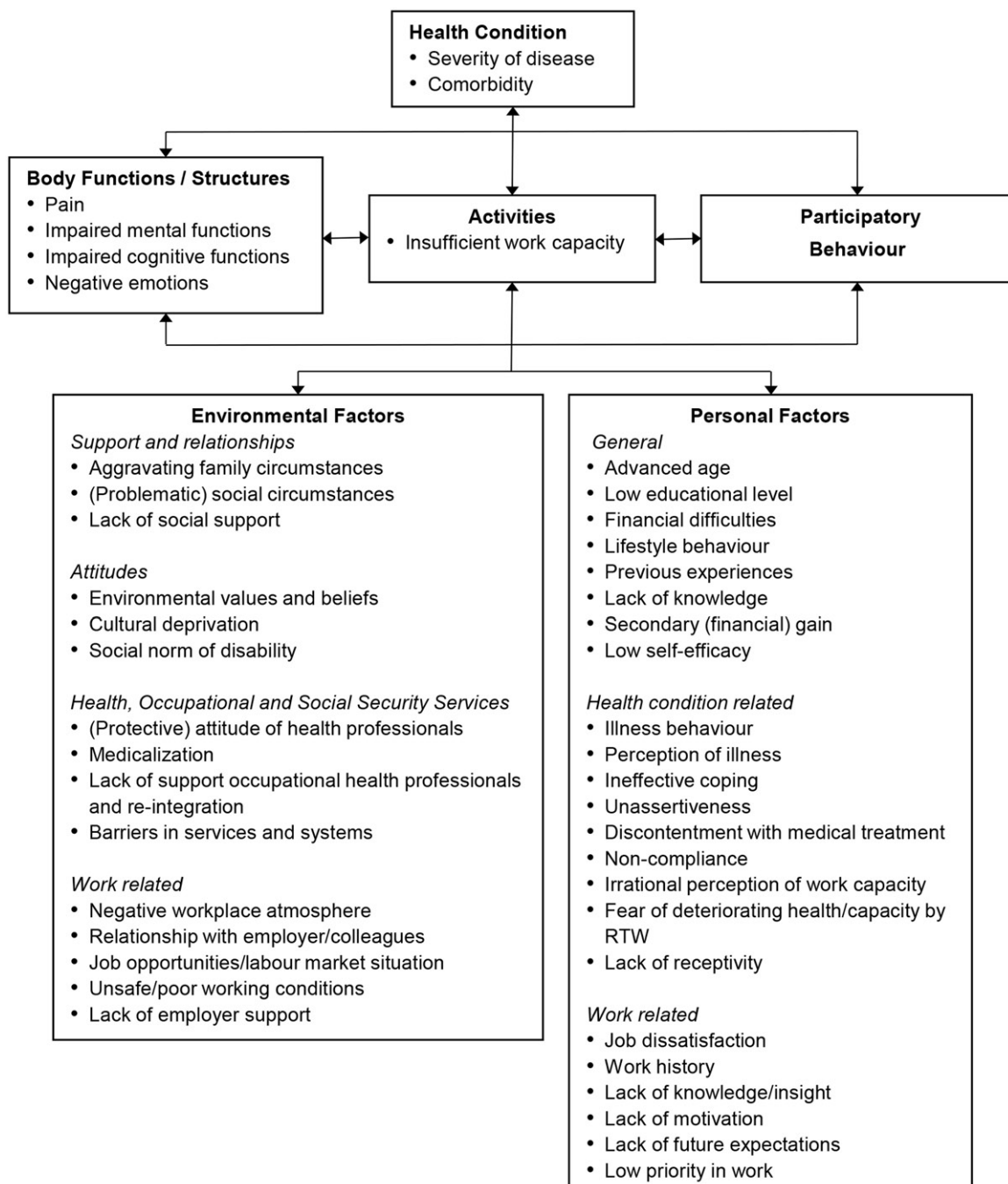


Figure 1. Factors of inadequate participatory behaviour classified according to the ICF.

perspective, including non-medical, that is, personal and environmental factors as well.

With regard to "inadequate participatory behaviour," responses of IPs were often exactly the opposite of their responses on "adequate participatory behaviour." This is understandable because adequate and inadequate are opposite terms. IPs frequently specify inadequate participatory behaviour as insufficient, for instance "insufficient (efforts to realize) participation in work" and "insufficient activity to improve health." Apparently, the quantity and quality of participatory behaviour as a whole performed by disability benefit claimants is important for IPs in deciding whether this behaviour is adequate or not.

The question is if disability benefit claimants can be held responsible for inadequate participatory behaviour, for example, by

passivity, that is, taking no initiative, doing nothing or doing less than what may be expected. They may lack knowledge on how to achieve RTW, as was put forward during the discussion meeting.

Some IPs listed specific behaviour as inadequate, such as refusal to work, not asking for help, having resistance and not keeping appointments, which was confirmed during the discussion meeting. This behaviour may indicate that some disability benefit claimants have other priorities than re-integration and returning to work or claimants may think that expected activities are not useful. Another possible explanation may be that some disability benefit claimants assess their work ability lower than their IP does.

Although "secondary gain," for instance financial gain, was frequently reported by IPs being a factor of inadequate participatory

behaviour, participants of the discussion meeting criticize the use of this expression. From their viewpoint, there is little gain in being ill and being disabled. Even if disability benefits are granted, beneficiaries suffer substantial financial loss in comparison with their former salary. The criticism is remarkable given the fact that many IPs in the PRGs associate inadequate participatory behaviour with “secondary gain.”

The expectation of some IPs that disability benefit claimants should adopt a healthier lifestyle is in line with the public debate on lifestyle and the consequences of unhealthy lifestyle behaviour for society in terms of associated costs [17–21]. However, holding disability benefit claimants responsible for their lifestyle was not supported during the discussion meeting. Disability benefit claimants cannot be compelled to maintain a healthy lifestyle, which would reflect a paternalistic attitude because it is impinging on their autonomy. There is an ongoing public debate on environmental factors that influence lifestyle and whether, in general, people can be held responsible for the consequences of unhealthy lifestyle behaviour. Opinions of IPs do not only reflect their individual and professional attitudes towards participatory behaviour, but are most likely also influenced by societal attitudes.

Another area in which IPs are confronted with disability benefit claimants’ autonomy and bodily integrity is adherence to medical treatment. Results of the discussion meeting indicated that a generalization on what is expected of disability benefit claimants regarding undergoing adequate medical treatment is not possible. For each individual disability benefit claimant, IPs should weigh the burden and risks of medical treatment against the potential gains in terms of expected improvement of disability benefit claimant’s functioning. It reflects the attitude of doctors and society towards medical treatment in general.

In-depth reflection during the discussion meeting resulted in consensus among IPs that within a biopsychosocial perspective it is not possible to formulate general criteria for the assessment of participatory behaviour for each unique case. Individual disability benefit claimant characteristics and circumstances are taken into account, conforming the ICF framework. This seems an adequate conclusion, given the complexity of the assessment of participatory behaviour. Therefore, this study shows that IPs adopt a tailor-made approach in their assessment of participatory behaviour is imperative, as shown by the opinions of the IPs in the PRGs. For example, the level of expected activities regarding participatory behaviour may be phase related [8,22]. During the acute phase of the disability process, disease-related impairments are most important, while re-integration activities are more relevant during the subacute and chronic phases. In addition, other individual characteristics, such as the kind of illness or diagnosis, illness beliefs, personality characteristics, cultural background, and social context are considered relevant.

The discussion meeting was primarily aimed to deepen the results of the PRGs and not to show possible differences between opinions expressed by IPs in the PRGs and the discussion meeting. Although IPs in the PRG and in the discussion meeting agree on important issues with regard to participatory behaviour, that is, the importance of the ICF and participatory behaviour as a combined effort, targeted at both health recovery and RTW, some opinions presented in the PRGs and in the discussion meeting seem to differ. This might have been the result of how the PRGs and the discussion meeting were organized as to composition and topics. In the PRGs, participatory behaviour was discussed by practicing IPs involved in general assessments of disability benefit claims. The expert IPs in the discussion meeting may have been more familiar with the

professional NVVG guideline on participatory behaviour [6] than the practicing IPs in the PRGs, since after its development this guideline was never implemented in practice by the SSI. In the discussion meeting, preselected topics concerning participatory behaviour were discussed by IPs selected from the PRGs, joined by three specialists on participatory behaviour, that is, two staff IPs and one IP who co-authored the NVVG guideline. This possibly resulted in a more thorough and in-depth discussion on participatory behaviour in the discussion meeting as compared to the PRGs.

Currently, participatory behaviour is not well-delineated, which may hinder IPs and other occupational health professionals to determine what exactly should be expected from disability benefit claimants. Consequently, disability benefit claimants may experience uncertainty in displaying expected participatory behaviour during a re-integration process, and not all disability benefit claimants will be able to comply with accompanying obligations and responsibilities. The opinion that participatory behaviour and the RTW process of disability benefit claimants is influenced by many different factors reflects the present knowledge on work disability and RTW processes [23], and illustrates the ongoing shift in insurance and occupational medicine from the traditional medical model to the biopsychosocial model.

Strengths and limitations

To the best of our knowledge, this is the first study that explored participatory behaviour and influencing factors from the perspective of IPs, who assess participatory behaviour as part of the disability benefit claim. A strength of this study is inclusion of IPs at PRG group level, representing IPs with a variety of specific expertise and long-established work experience. Moreover, the in-depth discussion meeting, attended by three experts on participatory behaviour, that is, two staff IPs and one IP who co-authored the NVVG guideline [6], deepened the interpretation of the newly gained knowledge. This contributed to a thorough and in-depth discussion on participatory behaviour during the discussion meeting.

A limitation of the study may be that we used the definition of participatory behaviour of the NVVG guideline [6] and did not evaluate whether this definition completely covers the concept participatory behaviour. The PRGs were guided by the regular chairmen. Although they received oral and written instructions in how to organize the meeting and how to guide the plenary discussion, differences between approaches of individual chairmen may have influenced the results.

Furthermore, data recording in the PRGs were limited to response forms and flip-charts. Standard methods in qualitative research, that is, audio recording of the proceedings in the PRGs, were expected to cause resistance among participating IPs, leading to a low response. As a result, qualitative data analysis of verbatim transcripts was not feasible in the PRGs. In-depth interviews with individual IPs could also have yielded more information on participatory behaviour, but we opted for the use of response forms because this made it possible to include more IPs in this first step aimed to explore participatory behaviour. Although the authors have comprehensive experience in qualitative research and researcher triangulation (two coders) was applied, subjectivity during the coding process may have influenced the credibility of the findings.

Lastly, we do not have information to assess whether the study sample of IPs is representative for all IPs involved in disability benefit assessment in the Netherlands.

Recommendations for further research and practice

The present study shows that Dutch IPs within the biopsychosocial ICF framework cannot formulate general applicable criteria for quantifying and qualifying "participatory behaviour." Therefore, further research and discussion in the field of occupational medicine is needed to achieve consensus on this complicated issue. It is also important to investigate which participatory behaviour is to be expected of disability benefit claimants, depending on whether their disability is short term or long term. This will enable a better understanding of adequate participatory behaviour, independent of occupational, societal or political ideologies and independent of personal convictions of disability benefit claimants and workers in occupational health. Future research may target to investigate how medical, personal and environmental factors should be weighed in individual cases. More knowledge on this complex interplay may improve IPs assessment of participatory behaviour in daily practice. Future research should also focus on other professionals working in occupational and insurance medicine, such as labour experts.

Furthermore, views of injured workers themselves are indispensable for a better understanding of participatory behaviour. At the moment, we are conducting a study to explore participatory behaviour from the perspective of disability benefit claimants on long-term sick leave. The differences in beliefs and attitudes between IPs and disability benefit claimants on participatory behaviour may reduce a fair granting of benefit and may possibly limit chances of RTW. More research is needed to clarify motivation and goals of disability benefit claimants regarding RTW. Furthermore, methods that enhance effective communication on issues regarding participatory behaviour between IPs and disability benefit claimants need to be developed.

Lastly, practicing IPs seems to be reasonably well informed about new insights and developments in their professional field, for example, the NVVG guideline on participatory behaviour. However, IP practice may benefit more from these innovations if guidelines including them are properly implemented [24].

Conclusions

In conclusion, views of IPs on disability benefit claimants' participatory behaviour reflect a broad biopsychosocial perspective. Identified factors seem to cover all ICF domains, including non-medical environmental and personal factors, next to factors related to health condition, body functions, and social- and work-related factors. By including ICF factors in their assessment of participatory behaviour and by viewing participatory behaviour as a combined effort directed both at health recovery and RTW, IPs adhere to their professional guideline. Nevertheless, within the ICF framework, it seems not attainable to formulate general applicable criteria for quantifying and qualifying participatory behaviour. Our results show that IPs adopt a nuanced tailor-made approach during assessment of disability benefit claimants' participatory behaviour and related expected activities aimed at recovery of health and RTW. Individual characteristics and circumstances of disability benefit claimants, such as stage and severity of disease, treatment, personal, environmental, and cultural factors, are taken into account.

This study indicates that some aspects of participatory behaviour extend beyond the boundaries of the domain where occupational health professionals operate. Opinions in society on

personal and societal responsibility regarding a variety of topics, such as physical and mental integrity, and autonomy and lifestyle, influence participatory behaviour.

For a thorough understanding of all aspects of participatory behaviour, further in-depth discussion and research is needed, including all relevant stakeholders, that is, professionals involved in the assessment of participatory behaviour, disability benefit claimants and society. The societal tendency that shows an increasing focus on individual responsibilities of disability benefit claimants should be balanced against the disability benefit claimants' abilities, or inabilities, to implement these responsibilities.

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